MONTANA DPHHS EDI PROVIDER ENROLLMENT FORM

MONTANA
Department of Public Health & Human Services

Please return to:
ACS-Inc
ATTN: MT EDI
PO Box 4936
Helena, MT 59604
Or fax to 406-442-4402

ACS

Provider Billing Agent/Clearinghouse ACS EDI Gateway, Inc Authorization Form

Section A. Provider Information.

Business Name	
Provider Name (Last, First, MI and Suffix)	
Provider Number	*Federal Tax ID Number*
Business Address	
City, State, and Zip	
Telephone Number	*Fax Number*
Contact Name	*E-mail Address*

Section B. Authorization Signature *(required).*

Provider, _____ hereby appoints

Provider name /Provider Representative name (please print)

_____, _____

Billing Agent/Clearinghouse name (please print) *Billing Agent/Clearinghouse ACS Trading Partner/Submitter ID*

to act as the authorized agent for the purpose of submitting health care transactions electronically to ACS EDI Gateway, Inc. Provider also authorizes the Billing Agent/Clearinghouse's access to the following X12N transaction responses if selected below:

- ☐ 277-Claims Status Response
- ☐ 271-Eligibility Response
- ☐ 824-Error Report
- ☐ 835-Healthcare Claims Payment Advice
- ☐ 278-Prior Authorization Response
- ☐ Exception Report (Print Image)
- ☐ 997-Functional Acknowledgement

_____

Provider/Provider Representative name (Please print)

_____ _____

Provider/Provider Representative Signature *Date*

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EDI PROVIDER ENROLLMENT FORM. Please print or type. Complete all areas of the Provider Enrollment Form, unless otherwise indicated.

Section 1. Classification. Please indicate your classification.

☐ **Individual Provider** ☐ **Group Provider**

☐ **Individual Pharmacy** ☐ **Branch Pharmacy** ☐ **Corporate Headquarters Pharmacy**

Section 2. Submission Method. Please indicate how you plan to submit your electronic transactions. (This section is not applicable to Pharmacies)

☐ **Asynchronous (Direct Submission to EDI)** ☐ **WINASAP2003** ☐ **Vendor Software**

☐ **Billing Agent** ☐ **Clearinghouse**

Section 3. Provider Information.

Business Name (If applicable)	
Provider Name (Last, First, MI, and Suffix)	
Business Street Address	
City, State, and Zip Code	
Telephone	*Fax*
Provider Number (Required for Individuals)	*Federal Tax ID Number*
Email Address (If applicable)	

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Section 4. Montana Submitter ID.	
If you are currently submitting electronic transactions directly to Montana FAS, please indicate your Montana 7-digit Submitter ID: **NOTE: This is your Montana DPHHS Submitter ID Assigned by FAS.**	☐☐☐☐☐☐☐

Section 4a. Submitter/Trading Partner ID Number.	
If you are currently submitting electronic transactions directly to ACS EDI Gateway, please indicate your ACS EDI Gateway 5-digit Submitter ID or 6-digit Trading Partner ID: **NOTE: This is NOT your Montana submitter ID**	☐☐☐☐☐☐

Section 5. Contact Information. Please indicate contact information.	
Contact Name	*Contact Title*
Business Street Address	
City, State, and Zip Code	
Telephone	*Fax*
Email Address	

Additional Contact Information. Please indicate additional contact information.	
Contact Name	*Contact Title*
Business Street Address	
City, State, and Zip Code	
Telephone	*Fax*
Email Address	

Please attach additional sheets if necessary.

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Section 6. Provider Using a Software Vendor, Billing Agent, or a Clearinghouse.
If you have indicated that you plan to use Vendor Software, a Billing Agent, or a Clearinghouse to submit your transactions electronically to ACS EDI Gateway, please provide the following information.
(If you plan on using WINASAP2003, you do not need to complete this section.)

Sub-section 6a. Type of Service that you use.

Please indicate the type of service that you use to submit electronic transactions.
(This section is not applicable to Pharmacies)

☐ **Software Vendor (SV)** ☐ **Clearinghouse (CH)** ☐ **Billing Agent (BA)**

SV/CH/BA Name			
Contact Name		***Contact Title***	
Business Address			
City, State, and Zip Code			
Telephone Number		***Fax Number***	
Email Address			

Sub-section 6b. Provider Using a Software Vendor.

If you plan to use Vendor Software, please complete the following information related to your software.

Software Name:		**Software Version:**		**Protocol:**	

Sub-section 6c. Software Vendor, Billing Agent or Clearinghouse Submitter ID or Trading Partner ID.

Note: Your Software Vendor, Billing Agent or Clearinghouse must be equipped with their own uniquely assigned ACS EDI Gateway Submitter ID or Trading Partner ID to act on your behalf. Please contact your Software Vendor, Billing Agent/Clearinghouse to confirm their status with ACS EDI.

Please indicate your Software Vendor/Clearinghouse/Billing Agent's ACS 5-digit Submitter ID or 6-digit Trading Partner ID: **NOTE: This is not your 7-digit Montana submitter ID assigned by FAS**	☐☐☐☐☐☐

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Section 7. Transactions Available for Transmission. (This section is not applicable to pharmacies)

Sub-Section 7a. WINASAP2003 (replacing ACE$ software).

Request for free WINASAP2003 Software:

☐ I will download a copy from the ACS website at http://www.acs-gcro.com/Medicaid_Accounts/Montana/montana.htm

☐ Please mail me a CD-ROM of the WINASAP2003 software.

☐ X12N 837P (Professional Claim)	☐ X12N 837D (Dental Claim)
☐ X12N 837I (Institutional Claim)	

Sub-Section 7b. Standard Transactions. Check all that apply (Submissions other than WINASAP2003)

☐ X12N 837P (Professional Claim)	☐ X12N 278 (Prior Authorization)
☐ X12N 837D (Dental Claim)	☐ X12N 270 (Eligibility Inquiry)
☐ X12N 837I (Institutional Claim)	☐ X12N 276 (Claim Status Inquiry)

Section 8. Delimiter Information.

If you are submitting X12N transactions directly to ACS, please provide an alternate delimiter if you are not using the default.

(This information is not required for users of WINASAP2003 and not applicable to pharmacies)

Element Delimiter to be used: ☐	Segment Delimiter to be used: ☐	Sub-Element Delimiter to be used: ☐
Default Delimiter (asterisk) *	*Default Delimiter (tilde)* ~	*Default Delimiter (colon)* :

Section 9. Electronic Response Retrieval. Check all that apply

All Montana providers can retrieve their electronic responses from Host Data Exchange (HDE). If you would like to participate in this service, please complete the section below.

Responses available for X12N Transactions.
(If you are a pharmacy your only valid selection is the X12N 835 Claim payment/advice)

☐ X12N 997 (Functional Acknowledgement)	☐ X12N 835 (Healthcare Claim Payment/Advice)
☐ X12N 271 (Eligibility Response)	☐ X12N 277 (Claims Status Response)
☐ X12N 278 (Prior Authorization Responses)	☐ X12N 824 (Error Responses)

☐ Exception Report (Print Images) ** If you have selected this option you must complete the Business Associate Agreement (BAA). Please call 1.800.987.6719 to request the BAA be faxed or mailed to you or go to http://www.acs-gcro.com/Medicaid_Accounts/Montana/EDI_Enrollment/edi_enrollment.htm and download the form. You may fax or mail this form to ACS EDI Gateway.

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Section 10. Additional Provider/Pharmacy List

Provider/Pharmacy Name	Provider/NCPDP ID (NABP)

Please attach additional sheets if necessary